STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055104	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Manor Conv Hosp	2720 Nevada Avenue El Monte, CA 91733

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on observation, interview, and record review, the facility failed to ensure the call light (an alerting device for nurses or other nursing personnel to assist a patient when in need) was within reach for one of one sampled resident (Resident 55). This failure had the potential to result in resident not receiving assistance in a timely manner when needed. Findings: During a review of Resident 55's Admission Record (AR), the AR indicated Resident 55 was admitted to the facility on [DATE] with diagnoses that included Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control) and tinea unguium (a fungal infection of the nails) During a review of Resident 55's Minimum Data Set (MDS, a resident assessment tool) dated 3/7/2025, the MDS indicated Resident 55 had clear speech, usually understood others and usually made self-understood. Resident 55 required substantial/maximal assistance (helper does more than half the effort, helper lifts or holds trunk or limbs and provides more than half the effort) for personal hygiene, eating and roll left and right. During an observation on 3/18/2025 at 11:08 am in Resident 55's room, Resident 55 was lying in bed. Resident 55's call light was wrapped outside of the left bedrail. Resident 55 stated Resident 55 was not able to find the call light and not able to reach it. During a concurrent interview, Licensed Vocational Nurse 2 (LVN 2), LVN 2 stated, Resident 55's call light was facing outside of the bedrail and Resident 55 needed help to reach it. LVN 2 stated the call light should be placed within easy reach of the resident to use to call for help when needed. LVN 2 stated Resident 55 could get hurt trying to get out of bed by himself if the call light was not within reach. During a review of the facility's Policy and Procedure (P&P) titled, Call Lights: Accessibility and Timely Response, dated 12/9/2024, the P&P indicated Staff will ensure the call light is within reach of the resident and secured, as needed.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 Based on interview and record review, the facility failed to ensure three of three sampled residents (Resident 30, 31 and 34) and/or their representatives were provided information regarding the right to formulate an advance directive (AD, legal documents that provide instructions for medical care and only go into effect if the person cannot communicate his/her own wishes) when: a. Resident 34 did not receive information regarding AD. b. Resident 30's AD Acknowledgement Form was filled out inaccurately. c. Resident 31's AD Acknowledgement Form was filled out inaccurately. These failures had the potential to result in Residents 30, 31, and 34 and/or their representatives to not be informed of their rights and receive unwanted and/or unnecessary life-sustaining care and treatment. Findings: a. During a review of Resident 34's Admission Record (AR), the AR indicated Resident 34 was readmitted to the facility on [DATE], with diagnoses that included diabetes mellitus (elevated blood sugars), cirrhosis of the liver (liver damage where healthy cells are replaced by scar tissue), and dependence on renal dialysis (a treatment for people whose kidneys are failing). During a review of Resident 34's History and Physical (H&P), dated 12/5/2024, the H&P indicated Resident 34 had the capacity to understand and make decisions. During a review of Resident 34's Minimum Data Set (MDS, a resident assessment tool), dated 1/31/2025, the MDS indicated Resident 34 was cognitively intact (able to think, learn, and remember) and required substantial/maximal assistance (helper does less than half the effort) with toileting hygiene and shower/bathing. During a concurrent interview and record review on 3/18/2025 at 3:13 pm with Licensed Vocational Nurse (LVN) 6, Resident 34's paper and electronic chart were reviewed. LVN 6 stated Resident 34 did not have an AD in her charts. LVN 6 stated the AD was important to document to know and record the resident's wishes and instruct the facility on who will carry them out. During an interview on 3/20/2025 at 3:46 pm with the Director of Nursing (DON), the DON stated the AD was important to determine the resident's wishes regarding provision of medical treatment and services. During an interview on 3/21/2025 at 9:52 am with Resident 34, Resident 34 was awake, alert and oriented. Resident 34 stated Resident 34 was not aware of an AD and staff did not provide was Resident 34 with any information about an AD. Resident 34 stated, I would like to know more to make good decisions about my care. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's policy and procedure (P&P) titled, Residents' Rights Regarding Treatment and Advance Directive, revised on 12/9/2024, the P&P indicated, It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive. The P&P indicated, The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advance directive. 42781 b. During a review of Resident 30's AR, the AR indicated Resident 30 was admitted to the facility on [DATE] with diagnoses that included abnormalities of gait (a person's manner of walking) and mobility (the ability to move) and need for assistance and personal care. During a review of Resident 30's H&P, dated 12/15/2024, the H&P indicated Resident 30 had the capacity to understand and make decisions. During a review of Resident 30's MDS, dated [DATE], the MDS indicated Resident 30 had moderate impaired cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated, Resident 30 required maximum assistance (helper does less than half the effort) with oral hygiene, upper body dressing and personal hygiene. The MDS indicated, Resident 30 was dependent (helper does all of the effort) on staff for toileting hygiene, shower, lower body dressing, and putting on or taking off footwear. During an interview and concurrent record review on 3/18/2025 at 2:46 pm, Resident 30's AD Acknowledgement Form was reviewed, with Social Service Director (SSD), the SSD stated, the AD Acknowledgement Form was not filled out accurately. The SSD stated, the form should indicate if Resident 30 [or Resident 30's responsible party] executed and had not executed and AD. The SSD stated, AD Form needed to be filled up accurately. c.During a review of Resident 31's AR, the AR indicated Resident 31 was admitted to the facility on [DATE] with diagnoses that included type 2 diabetes mellitus (a disease in which the body's ability to produce or respond to the hormone insulin is impaired, resulting in elevated levels of glucose/sugar in the blood and urine). During a review of Resident 31's MDS, dated [DATE], the MDS indicated, Resident 31 had intact cognition for daily decision making. The MDS indicated, Resident 31 required maximum assistance with shower and putting on/taking off footwear. The MDS indicated, Resident 31 require moderate (helper does less than half of the effort) with toileting hygiene, upper body dressing and lower body dressing. During an interview and concurrent record review on 3/18/2025 at 3:02 pm, with LVN 5, Resident 31's AD Acknowledgement Form was reviewed. LVN 5 stated, Resident 31 did not execute an AD. LVN 5 stated, I filled up the AD Form incorrectly. LVN 5 stated an AD was legal documentation for medical decisions indicating [Resident 31's] wants and wishes during [medical] emergencies. During an interview on 3/20/2025 at 10:20 am, with the facility's Director of Nursing (DON), the DON stated, AD Acknowledgement Forms needed to be filled out completely. The facility's DON stated the AD Form's purpose was to know what the resident's wants and wishes were in case of [medical] emergencies. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a review of the facility's Policy and Procedure (P&P), titled, Residents' Rights Regarding Treatment and Advance Directives, revised 12/9/2024, the P&P indicated, on admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident, if cognitively able to, would like to formulate advance directive. The P&P indicated. Upon admission, should the resident have an advance directive, copies will be made and placed on the chart as well as communicated to the staff.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on observation, interview, and record review, the facility failed to provide an effective communication method to one of two non-English speaking sampled residents (Resident 7). This failure had the potential for the resident not to receive necessary care and services. Findings: During a review of the Resident 7's Admission Record (AR), the AR indicated Resident 7 was admitted to the facility on [DATE], with diagnoses that included Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control) dysphagia (difficulty swallowing) and pressure-induced deep tissue damage of the right heel (pressure ulcer/injury, PU/PI, localized damage to the skin and/or underlying tissue usually over a bony prominence). During a review of Resident 7's Minimum Data Set (MDS, a resident assessment tool) dated [DATE], the MDS indicated Resident 7's preferred language was Vietnamese. The MDS indicated Resident 7 had no speech, rarely/never understood others and made self-understood. The MDS indicated Resident 7 was dependent (helper does all of the effort) with eating, oral/toileting hygiene, showering and personal hygiene. During an observation on [DATE] at 10:24 am, in Resident 7's room, Resident 7 was lying in bed with eyes open. Resident 7's daughter/responsible party (RP 1) was at bedside. Resident 7 did not understand when asked questions in English. RP 1 stated, Resident 7 was Vietnamese speaking and able to communicate for basic needs if talking to Resident 7 in Vietnamese language. There was no communication board (paper pamphlet that displays photos, symbols, or illustrations to help people with limited language skills express themselves) at Resident 7's bedside. During an interview on [DATE] at 10:34 am, Certified Nursing Assistant 2 (CNA 2), CNA 2 stated Resident 7 spoke Vietnamese and there was no communication board at Resident 7's bedside. CNA 2 stated, CNA 2 utilized a coworker as a method of translation to communicate with Resident 7 and the co-coworker who spoke Vietnamese was not working today ([DATE]). CNA 2 stated, CNA 2 did not have other ways to communicate with Resident 7. CNA 2 stated it was important to communicate with the resident to ensure care was provided. During an interview on [DATE] at 10:38 am with Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated the facility should provide communication board at bedside for non-English speaking residents so that staff understood the residents, provide better care and improve the residents' quality of life. During a record review of Resident 7's Care Plan Report (CPR, a comprehensive document that outlines the specific healthcare goals, interventions, and monitoring strategies for an individual resident) dated [DATE], the CPR indicated Resident 7 had a communication problem related to language barrier (Vietnamese) and for staff to provide a communication board for the resident. (continued on next page)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P) titled Communication with Person with Limited English Proficiency, dated [DATE], the P&P indicated Language assistance will be provided through use of competent bilingual staff, staff interpreters, contracts or formal arrangements with local organizations providing interpretation or translation services, or technology an d telephonic interpretation services.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40037 Based on observation, interview and record review, the facility failed to follow the physician's order to keep the resident's both heels to free float (technique where the heels were completely elevated off the surface) for one of three sampled residents (Resident 7). This failure had the potential risk for Resident 7 to develop pressure injury (PI, localized damage to the skin and/or underlying tissue usually over a bony prominence) and delayed healing of existing PI. Findings: During a review of the Resident 7's Admission Record (AR), the AR indicated Resident 7 was admitted to the facility on [DATE], with diagnoses that included Diabetes Mellitus (DM, a disorder characterized by difficulty in blood sugar control) dysphagia (difficulty swallowing) and pressure-induced deep tissue damage of the right heel (pressure ulcer/injury, PU/PI, localized damage to the skin and/or underlying tissue usually over a bony prominence). During a review of Resident 7's Order Summary Report (OSR) dated 2/4/2025, the OSR indicated an order to free float left and right heel using pillows to prevent pressure on the heels. During a review of Resident 7's Minimum Data Set (MDS, a resident assessment tool) dated 2/7/2025, the MDS indicated Resident 7 had no speech, rarely/never understood others and made self-understood. The MDS indicated Resident 7 was dependent (helper does all of the effort) with eating, oral/toileting hygiene, showering and personal hygiene. During an observation on 3/18/2025 at 10:24 am in Resident 7's room, Resident 7 was lying in bed with eyes open. Resident 7's left heel was wrapped and covered by gauze. Resident 7's both feet were resting on the bed mattress. During an observation on 3/18/2025 at 3:06 pm in Resident 7's room, Resident 7 was lying in bed with both heels resting on the bed mattress. During a concurrent interview, Licensed Vocational Nurse 1 (LVN 1) stated Resident 7 had left heel PI upon admission. LVN 1 stated, staff should follow the physician's order to free float both Resident 7's heels from the bed mattress to avoid adding pressure to the heels and to prevent Resident 7 from developing new PI or worsen the old PI on the left heel. During an interview on 3/19/2025 at 12:41 pm with the Director of Nursing (DON), the DON stated the physician's order for Resident 7 should be followed by all staff. The DON stated, Resident 7's heels should be offloaded to promote healing of the left heel PI and to prevent developing new PI and/or worsen the current PI on the resident's left heel. The DON stated it was important to provide quality of care for the resident's quality of life. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's Policy and Procedure (P&P) titled Pressure Injury Prevention and Management dated 1/31/2025, the P&P indicated interventions for prevention and to promote healing, evidence-based interventions for prevention will be implemented for all residents who are assessed at risk or who have a pressure injury present. Basic or routine care interventions could include, but are not limited to redistribute pressure (such as repositioning, protecting and/or offloading heels, etc.)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 Based on interview and record review, the facility failed to provide the necessary care and services for one of one sampled resident (Resident 34), who required and received hemodialysis (treatment for kidney failure that removes waste and extra fluids from the blood) four times a week, by failing to ensure staff followed Resident 34's physician's order for fluid restrictions of 1200 milliliters (ml- unit of measurement) a day. This deficient practice had the potential for Resident 34 to experience fluid overload (excessive amount of fluid in the body) and difficulty breathing that can compromise the Resident 34's health. Findings: During a review of Resident 34's Admission Record (AR), the AR indicated Resident 34 was readmitted to the facility on [DATE], with diagnoses that included diabetes mellitus (elevated blood sugars), cirrhosis of the liver (liver damage where healthy cells are replaced by scar tissue), and dependence on renal dialysis (a treatment for people whose kidneys are failing). During a review of Resident 34's History and Physical (H&P), dated 12/5/2024, the H&P indicated Resident 34 had the capacity to understand and make decisions. During a review of Resident 34's physician order (PO), dated 1/5/2025, the PO indicated Resident 34 had an order for hemodialysis every Tuesday, Wednesday, Thursday, and Saturday at Hemodialysis Center 1. During a review of Resident 34's PO dated 1/5/2025, the PO indicated Resident 34 had an order for 1200 ml fluid restriction: Nursing to provide 240 ml per day shift, 240 ml per evening shift, and 120 ml per night shift to total 600 ml. The PO indicated Dietary to provide 200 ml for breakfast, 200 ml for lunch, and 200 ml for dinner to total 600 ml. During a review of Resident 34's Minimum Data Set (MDS, a resident assessment tool) dated 1/31/2025, the MDS indicated Resident 34 was cognitively intact (able to think, learn, and remember) and required substantial/maximal assistance (helper does less than half the effort) with toileting hygiene and shower/bathing. During a concurrent interview and record review on 3/20/2025 at 3:54 pm with the Director of Nursing (DON), Resident 34's paper and electronic chart were reviewed. The DON stated Resident 34's medical record indicated no documentation regarding restricting fluid intake for Resident 34. The DON stated, There was no system to monitor how much fluid the resident was receiving a day. The DON stated following residents' (in general) physician's orders, especially about fluid restrictions for residents on hemodialysis, was important to prevent fluid overload. During an interview on 3/21/2025 at 9:51 am with Resident 34, Resident 34 stated, They (facility) don't tell me how much fluid I can drink here. I usually get and drink what I want. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the facility's policy and procedure (P&P) titled, Fluid Restriction, revised 1/31/2025, the P&P indicated, It is the policy of this facility to ensure that fluid restrictions will be followed in accordance to physician's orders. The P&P indicated, Fluid restrictions are basically the restriction of fluid intake.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 Based on interview and record review, the facility failed to ensure irregularities identified from the monthly drug regimen review reported by the facility's pharmacist were acted upon for two of five sampled residents (Residents 20 and 34): a. Resident 34's pharmacist recommendation to order laboratory test to monitor the increased risk of rhabdomyolysis (a serious medical condition of a breakdown of muscle tissue, releasing harmful substances into the bloodstream) was not acted upon. b. Resident 20's pharmacist recommendation to discontinue Benadryl (medication to treat pain and itching) was not acted upon. These deficient practices had the potential for unnecessary medication administration. Findings: a. During a review of Resident 34's Admission Record (AR), the AR indicated Resident 34 was readmitted to the facility on [DATE] with diagnoses that included diabetes (elevated blood sugar), cirrhosis of the liver (liver damage replaced by scar tissue) and dependence on renal dialysis (a treatment for people whose kidneys are failing). During a review of Resident 34's History and Physical (H&P) dated 12/5/2024, the H&P indicated Resident 34 had the capacity to understand and make decisions. During a review of Resident 34's Physician Orders (PO) dated 1/5/2025, the PO indicated for Resident 34 to receive Lipitor (Atorvastatin, a statin [a class of medication] that can treat high cholesterol and triglyceride levels) 10 milligrams (mg-unit of measurement) by mouth (PO) nightly (HS) and Tricor (Fenofibrate, a fibric acid [a class of lipid lowering medication] a medication to lower high cholesterol and triglyceride levels) 145 mg by mouth in the afternoon (QD). During a review of Resident 34's Minimum Data Set (MDS, a standardized assessment and care-screening tool) dated 1/31/2025, the MDS indicated Resident 34 was cognitively intact and required maximal assistance (helper does less than half the effort) with toilet hygiene, shower and bathing. During a review of Resident 34's Medication Administration Record (MAR) for March 2025, the MAR indicated Resident 34 received Lipitor 10 mg PO HS by mouth nightly (HS) and Tricor (Fenofibrate, 145 mg PO in the afternoon (QD) from 3/1/2025 to 3/18/2025. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During a record review of a document titled Note to Attending Physician/Prescriber ([NAME]), from the facilities pharmacist, dated 2/27/2025, the [NAME] indicated, The resident currently received Fenofibrate and Lipitor daily and to be aware that fibric acid in combination with a statin can increase the risk of rhabdomyolysis and require careful monitoring as to new labeling changes are no longer approved a fibric acid to be used with statins due to lack of CV (cardiovascular) benefit and more risks with the combos and to please consider ordering a FLP(a blood test the measures cholesterol and triglyceride level after a period of fasting) . to re-evaluate if Fenofibrate could be discontinued or assess risk versus benefit of continued concurrent (the same time). The [NAME] portion titled Physician/Prescribers Response, was left blank. During an interview with the facility's Director of Nursing (DON) on 3/20/2025 at 4:04 pm and a concurrent record review of Resident 34's electronic and paper chart, the DON stated as of 3/20/2025, Resident 34 was currently receiving Tricor and Lipitor. The DON stated the pharmacist recommendation review (MRR) should be followed as soon as possible, within a week. The DON stated following up on pharmacist recommendations were important to ensure the resident's medication were regulated by a pharmacist and residents received proper/safe medications. 42781 b.During a review of Resident 20's AR, the AR indicated Resident 20 was admitted to the facility on [DATE] with diagnoses that included personal history of other infectious and parasitic (an organism, or living thing, that lives on or inside another organism) diseases. During a review of Resident 20's MDS, dated [DATE], the MDS indicated Resident 20 had intact cognition (mental action or process of acquiring knowledge and understanding) for daily decision making. The MDS indicated Resident 20 required maximum assistance (helper does less than half the effort) with toileting hygiene and lower body dressing. During a review of Resident 20's Order Summary Report (OSR), dated active as of 3/20/2025, the OSR included the following physician orders, 1.Allergy Relief Oral Tablet 10 mg (Loratadine, [Claritin is the common brand name] medication used to treat allergy symptoms, including runny or stuffy nose, sneezing, watery eyes, and itching of the eyes, nose or throat), give one (1) tablet by mouth in the morning for allergy relief, start date 12/22/2023. 2. Benadryl Allergy (medication used to treat allergic reactions) oral tablet 25 mg by mouth every six (6) hours as needed for itching, start date 12/6/2024. During a review of a facility document (regarding Resident 20) titled, Note to Attending Physician/Prescriber, dated 1/31/2025, completed by the facility's PC, the note's recommendation indicated if Resident 20 had a chronic (long standing) itch, to consider discontinuing as needed Benadryl and start Claritin (Loratadine) 10 mg by mouth daily for chronic itch. During a concurrent record review and interview with Licensed Vocational Nurse 1 (LVN 1) on 3/20/2025 at 9:47 am, Resident 20's medical record (chart) was reviewed. LVN 1 stated Benadryl was not discontinued. LVN 1 stated, the purpose of MRR was for the pharmacy to check the medications monthly to control [administration of] unnecessary medications the residents were taking. (continued on next page)

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	055104	A. Building B. Wing	03/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunset Manor Conv Hosp	2720 Nevada Avenue El Monte, CA 91733

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/20/2025 at 9:55 am, with the facility's Director of Nursing (DON), the DON stated, the MRR was a monthly recommendation [from the pharmacist] that licensed nurses were supposed to carry out. The DON stated, there was no other clinical documentation that indicated the monthly recommendation [to discontinue Benadryl for Resident 20] from the pharmacist dated 1/31/2025 was carried out. During a review of the facility's Policy and Procedure (P&P), titled Medication Regimen Review, revised on 1/31/2025, the P&P indicated the drug regimen was reviewed at least once a month by a licensed pharmacist and included a review of the resident's medical chart. The P&P indicated, if the pharmacist should identify an irregularity that required urgent action to protect a resident, the DON or designee was informed . Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38108 Based on observation, interview, and record review, the facility failed to ensure safe and sanitary conditions were maintained in one of one facility kitchen. During initial tour of the kitchen, a 22-ounce (oz) bottle of basil pesto sauce was observed with an unreadable best by or used by date. This deficient practice had the potential for improper food storage, which could lead to foodborne illnesses (illness caused by consuming contaminated food or beverages) to the residents who received food from the kitchen. Findings: During an initial tour and observation of the kitchen on 3/18/2025 at 8:58 am with the Assistant [NAME] (AC), a 22 oz. bottle of pesto sauce was observed inside the facility's freezer. The AC stated the pesto sauce bottle's use by or best by date was unreadable. The AC stated best by or used by dates were important to determine when the product was edible for consumption and when to discard to prevent possible food borne illnesses to the residents. During a review of the facility's Policy and Procedure (P&P) titled Date Marking for Food Safety, revised 1/31/2025, the P&P indicated the facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety food. The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded.

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38108 Based on interview and record review, the facility failed to ensure for one of three sampled residents (Resident 6) whose primary language was Spanish, the binding arbitration agreement (AA, a private process where disputing parties agree that one or several other individuals can plan about the dispute) was fully understood by the resident and was presented in a language Resident 6 understand. This deficient practice had the potential for the resident to not be fully informed and make an informed decision on whether to enter into such agreement. Findings: During a review of Resident 6's Admission Record (AR), the AR indicated Resident 6 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnosis that included atrial fibrillation (irregular heart rate), hypertension (elevated blood pressure) and dependence on supplemental oxygen. During a review of Resident 6's History and Physical (H&P) dated 2/12/2025, the H&P indicated Resident 6 had the capacity to understand and make decisions. During a review of Resident 6's Minimum Data Sheet (MDS, a resident assessment and care screening tool) dated 2/14/2025, the MDS indicated Resident 6's preferred language was Spanish. During an interview with Resident 6 on 3/20/2025 at 3:12 pm, Resident 6 was awake, alert and oriented to name, date and place. Resident 6 was presented with an AA in English dated 3/20/2025 and the AA was signed by the resident. Resident 6 confirmed Resident 6's signature and stated Resident 6 was asked to sign the AA the morning of 3/20/2025 by the Admission Director (AD). Resident 6 further stated Resident 6 spoke and read only in Spanish and did not know what the AA meant. During an interview with Licensed Vocational Nurse 4 (LVN 4) on 3/20/2025 at 3:13 pm, LVN 4 stated Resident 6 spoke and read only in Spanish. During an interview with the AD on 3/20/2025 at 3:15 pm, the AD stated Resident 6 spoke and read in Spanish. The AD stated the AD presented and asked Resident 6 to sign the AA written in English but was unsure if Resident 6 understood what the document (AA) meant. AD stated it was important for the residents to be aware and agree of the agreement they were signing as part of the residents' dignity and rights. During an interview with the facility's Director of Nursing (DON) on 3/250/2025 at 3:38 pm, the DON stated the AA was a legal document. The DON stated it was the right of Resident 6 to be aware and fully comprehend what Resident 6 was signing and agreeing to. The DON stated the AA should be presented to Resident 6 in Spanish. During a review of the facility's Policy and Procedure (P&P) titled Binding Arbitration Agreements, revised 1/31/2025, the P&P indicated when explaining the arbitration agreement, the facility shall (continued on next page)

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F 0847 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	a. Explain to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands. b. Ensure the resident or his or her representative acknowledge that he or she understands the agreement.

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Based on observation, interview, and review the facility's waiver request, the facility failed to ensure one of 28 resident's room in the Sub Acute Unit accommodated no more than four residents in a multiple resident room. room [ROOM NUMBER] had five beds to accommodate five residents. This deficient practice had the potential risk for privacy concerns and crowded condition in the room. Findings: During an entrance conference with the facility Administrator (ADM) on 3/18/2025 at 9:51 am, the ADM stated the facility had one room (room [ROOM NUMBER]) that had more than four residents occupying the room. The ADM stated, the facility would request a room waiver for six (6) beds in room [ROOM NUMBER]. During the Health Recertification Survey from 3/18/2025 to 3/21/2024, room [ROOM NUMBER] was observed with five resident beds, side tables, dresser and resident care equipment. Staff were able to move freely inside the room. Out of the 5 beds inside room [ROOM NUMBER], four beds were occupied by residents. During an interview on 3/18/2025 at 10:43 am with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated there were five beds in room [ROOM NUMBER] with four beds occupied. The LVN 3 stated, there was enough space in the room to provide care and treatment to the residents with ventilators (machine that supports breathing) with no issues. LVN 3 stated, the room was big enough to accommodate residents. During a review of the facility's letter to request for room waiver dated 3/18/2025, the letter indicated the room (room [ROOM NUMBER]) contained five beds and had 500.4 square footage (sq. ft, unit of measurement) and the facility was requesting a room waiver for six beds in room [ROOM NUMBER]. The waiver indicated the rooms were in accordance with special needs of residents and there was no adverse effect to the health, and safety or impede the ability of any residents to attain highest practicable well-being. The waiver indicated, the resident's safety was not compromised by the existing square footage and the room size did not affect resident's safety and the care provided.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42781 Amended : 5/13/2025. The facility submitted a Revised Room Waiver Request Letter dated 5/12/2025. Based on observation, interview and record review, the facility failed to ensure 9 of 28 rooms (Rooms 16,19, 20, 21, 22, 25, 26, 27 and 32) met the square footage requirement of 80 square feet (sq. ft.) per resident in multiple resident rooms. This deficient practice had the potential to impact resident's safety and the ability of staff to provide safe nursing care and privacy to the residents. Findings: During an interview with the facility Administrator (ADM) on 3/18/2025 at 9:51 am, the ADM stated the facility would like to request a room waiver (a document recording the waiving of a right or claim) for Rooms 15, 16, 17, 19, 20, 21, 22, 23, 25, 26, 27, 32, 33 and 35. The ADM stated nothing was changed in the number of bed occupancy in Rooms 15, 16, 17, 19, 20, 21, 22, 23, 25, 26, 27, 32, 33 and 35 from last year. During the Health Recertification Survey from 3/18/2025 to 3/21/2025, Rooms 15, 16, 17, 19, 20, 21, 22, 23, 25, 26, 27, 32, 33 and 35 had adequate space and nursing care, comfort and privacy were provided to the residents. The residents were observed to have enough space to move freely inside the rooms. There was an adequate room for the operation and use of the wheelchairs (a chair fitted with wheels for use as a means of transport by a person), walkers (a device that gives additional support to maintain balance or stability while walking) and Hoyer lift (a mechanical device used to lift and/or transfer a person from place to place). Each resident inside the affected rooms had beds and bedside tables with drawers. The room size did not affect the care and services provided by the staff to the residents when staff were observed providing care to the residents. During an interview on 3/18/2025 at 10:23 am with Certified Nurse Assistant 4 (CNA 4), CNA 4 stated, there was enough space in the rooms and staff were able to provide care to the residents. CNA 4 stated CNA 4 was able to move wheelchairs, Hoyer lifts and walkers inside the rooms with no issues. During an interview on 3/18/2025 at 10:43 am with Licensed Vocational Nurse 1 (LVN 1), the LVN 1 stated there was enough space to provide care and treatment to the residents with ventilators (machine that supports breathing) with no issues. LVN 1 stated there was enough space for the bed and staff were able to move wheelchairs and Hoyer Lifts inside the rooms. During an observation in room [ROOM NUMBER] and interview on 3/19/2025 at 9:34 am with Resident 30, Resident 30 was sitting in his wheelchair inside Resident 30's room next to his bed. Resident 30 stated, there was enough space in the room and Resident 30 was able to wheel himself in and out of the room with no issues. (continued on next page)

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	During a review of the facility's letter to request for room waiver dated 3/18/2025, revised 5/12/25, the letter indicated the rooms were in accordance with the special needs of the residents and there was no adverse effect on the resident's health and safety nor impede the ability of any residents to attain their highest practicable wellbeing. The waiver indicated, the resident's safety were not compromised by the existing square footage and the room size did not affect the resident's safety and care provided. On 5/12/2025 at 2:17 pm, the facility submitted a Revised Room Waiver Request Letter dated 5/12/2025 and revised Client Accomodation Analysis dated 5/12/2025. During a review of the Revised Client Accommodations Analysis, revised 5/12/2025, the client accommodations analysis indicated the following: Room Sq. Ft. Beds 16 136.7 2 19 212.8 3 20 150.3 2 21 214.7 3 22 145.2 2 25 145.2 2 26 141 2 27 139.7 2 32 234.9 3 During a telephone interview with the Administrator on 5/13/2025 at 11:55 am, the Administrator stated Rooms 15, 17, 23, 33 and 35 were removed from the waiver letter and no longer being requested. The Administrator stated the new maintenance team had re-measured and Rooms 15, 17, 23, 33 and 35 met the minimum requirement of 80 sq ft without needing a waiver.